

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 27 1949

State File No. 28109
3304

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI b. COUNTY ST. LOUIS,	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LEMAY MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY HOSPITAL		d. STREET ADDRESS (If rural, give location) R-2027 LEMAY FERRY RD	
3. NAME OF DECEASED a. (First) Eugenia		b. (Middle)	
c. (Last) HAAKE		4. DATE OF DEATH (Month) (Day) (Year) AUG 20, 1949	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 8/11/1890
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	
10b. KIND OF BUSINESS OR INDUSTRY GRAND LEADER		11. BIRTHPLACE (State or foreign country) ST. ROSE ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME GEORGE HAAKE	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE HERMAN HAAKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 500-30-2597	
17. INFORMANT'S SIGNATURE OR NAME ALOIS HAAKE		ADDRESS 2027 LEMAY FERRY ROAD	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombus ANTECEDENT CAUSES DUE TO (b) Endocarditis DUE TO (c) Tachycardia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ---	
INTERVAL BETWEEN ONSET AND DEATH 2 hour		5 days	
5 days		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION ----	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 95a		(STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? #202			
22. I hereby certify that I attended the deceased from March 20, 1948 to August 20, 1949 , that I last saw the deceased alive on August 20, 1949 , and that death occurred at 12:30 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE W. O. Simpson (Degree or title)		23b. ADDRESS 3739 Gravois	
23c. DATE SIGNED 8-22-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 8/21/49	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) BREESE ILLINOIS	
DATE REC'D BY LOCAL REG. AUG 23 1949		REGISTRAR'S SIGNATURE J. B. Lantieri	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

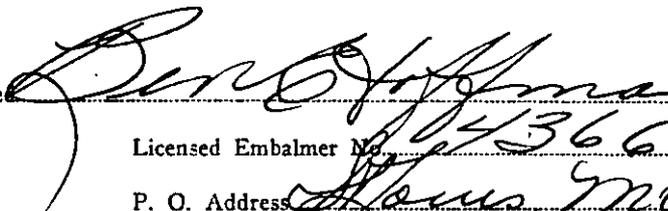
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed 

Licensed Embalmer No. 4366

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.